N.C. Department of Health and Human Services
Division of Medical Assistance
Medicaid Managed Care Program
PRENATAL RECORD AUDIT OF MATERNAL HEALTH SERVICES

Patient's Medicaid #: _____

Patient Name: _____

Race: _____ DOB: (Downloaded information)

System of Care: (Downloaded information)

CA Provider or HMO Group #: (Downloaded information)

Physician/Practiced Reviewed: _____

County of Care Code: (Downloaded information)

Reviewer: _____ Date of MRNC Review: _____

PATIENT INFORMATION:

Marital Status		
	GRADE:	
Highest level of education completed		
	DATE:	
LMP		
EDC (EDD)		
Date of first prenatal visit for this pregnancy after pregnancy confirmed		
Date of last prenatal visit for this pregnancy		
	WEEKS:	
Gestational age at last visit for this pregnancy		
	DATE:	
Date of Delivery		
	GRAMS:	**POUNDS & OUNCES:**
Weight of Baby		

PROVIDER INFORMATION:

	DATE	
Date of initial prenatal visit with the practice being reviewed		
	Yes	**NO**
Documentation that other prenatal care was provided by any practice other than the practice being reviewed excluding first prenatal visit for this pregnancy		
The prenatal records from the other practice are included in the chart		
Did the practice being reviewed use the ACOG Antepartum Record/Flow Sheet		

COMPONENTS FOR PRENATAL CARE:

	Yes	No
Comprehensive past medical history		
Documentation patient was asked about substance abuse history		
Documentation of substance abuse history during this pregnancy		
Documentation of substance abuse counseling or education		

	YES	NO	N/A
Medications listed			

	Yes	No
Allergies listed		
Documentation patient was asked about menstrual history		
Documentation patient was asked about past pregnancies		
Comprehensive initial physical exam		
Documentation of nutrition counseling or education		
Documentation of prenatal vitamins		

	Yes	No
Education on danger signs & symptoms of pregnancy and/or preterm labor symptoms		
Education on physical limitation or exercise		
Education on safe sexual practices		

	Yes	No
Documentation patient was assessed for genetic risks		
Documentation patient had genetic risks		
Counseling or education on genetic risks		

	Yes	No
Documentation of High Risk condition		
Documentation of management of high risk condition		

COMPREHENSIVE INTERIM (PRENATAL) EXAMS:

	YES	NO
Weight		
BP		
Urine protein/glucose dip stick		
Fundal Height or Uterine size		
Fetal Heart Rate or Tone (FHR/FHT)		
Fetal movement		
Danger signs & symptoms of preterm labor		
Abnormalities Identified On Any Visit		
Documentation of abnormalities managed/addressed by provider		

PROVIDER FOLLOW-UP:

	YES	NO
Documentation of missed scheduled appointments for this patient for the practice (site) being reviewed		
Documentation of follow-up by practice for missed appointments for this patient		
Patient referred for inter/intra office medical services or consultations		
Documentation that patient received medical services or consultations for which referred		

INITIAL LABORATORY TESTS:

	DATE		
Blood type/Rh factor			
	POSITIVE	NEGATIVE	NOT DOC.
Rh factor results			
	DATE		
Hemoglobin or hematocrit			
	DATE		
Antibody screen			
	POSITIVE	NEGATIVE	NOT DOC.
Antibody screen results			
	DATE		
Pap Test			
Rubella antibody titer			
Urinalysis			
Urine culture			

	YES	NO
Documentation of history of positive Hepatitis B		
	DATE	
Hepatitis B surface antigen test		

	DATE		
Syphilis test			
	REACTIVE	NONREACTIVE	NOT DOC.
Syphilis test results			
	YES	NO	
Antibiotic prescribed			
	DATE		
Syphilis <u>retest</u> date after antibiotic completion			

	DATE		
Gonorrhea Culture			
	POSITIVE	NEGATIVE	NOT DOC.
Gonorrhea Culture results			
	YES	NO	
Antibiotic prescribed			

INITIAL LABORATORY TESTS (CONT'D)

	DATE
Culture <u>retest</u> date after antibiotic completion	

	DATE		
Chlamydia test (CMZ)			
	POSITIVE	NEGATIVE	NOT DOC.
Chlamydia test results			
	YES	NO	
Antibiotic prescribed			
	DATE		
Chlamydia <u>retest</u> after antibiotic completion			

	YES	NO
Documentation of history of positive HIV		
	DATE	
HIV Education/counseling for testing		
	YES	NO
Documentation of HIV Test refusal		
	DATE	
HIV Testing		
	POSITIVE	NEGATIVE	NOT DOC.
HIV test results			
	YES	NO
Documentation of management of HIV disease		

INTERIM LABORATORY TESTS:

	YES	NO
Documentation of MSAFP/Multiple Markers test refusal		
	DATE	
MSAFP/Multiple Markers test		
	DATE	
Ultrasound		

	YES	NO
Documentation of history of diabetes mellitus		

	DATE
Diabetes screening	

	YES	NO	NOT DOC.
Abnormality of diabetes screening			

	DATE
Oral Glucose Tolerance Test (OGTT)	

	YES	NO	NOT DOC.
Abnormality of OGTT			

	YES	NO
Documentation of diabetes management		
Documentation of insulin dependent diabetes		
Documentation of Non-Stress Test (NST)		

	DATE
Syphilis repeat	
Gonorrhea culture repeat	
Chlamydia repeat	

	YES	NO
Documentation of history of herpes		
Documentation of presence of genital lesion		

	DATE
Herpes culture	

	DATE
Hgb or Hct repeat	

	DATE		
Beta-hemolytic streptococci test (Group B strep)			
	POSITIVE	NEGATIVE	NOT DOC.
Group B strep test results			

	YES	NO
Antibiotic Administered during intrapartum		

INTERIM LABORATORY TESTS CONT'D:

	DATE		
Antibody screen repeat			
	POSITIVE	**NEGATIVE**	**NOT DOC.**
Antibody screen repeat results			
	YES	**NO**	
D(RhoD) Immune Globulin administered			

NOTES:_____
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